STATE OF MONTANA - DEPT. OF PUBLIC HEALTH & HUMAN SERVICES

FOR USE BY PHARMACIES

PLEASE TYPE OR PRINT

FORM NO. MA-5

NAME & ADDRESS OF PROVIDER OF SERVICES	NABP NO.	MAIL TO CLAIMS PROCESSING UNIT DEPT. MA-5 PO.O BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958 406-442-1837	DO NOT WRITE IN THIS SPACE

CLIENT LAST NAME	FIRST	MIDDLE INITIAL	M S E X F	DATE OF BIRTH MO. DAY YEAR	COUNTY	CLIENT NUMBER

	Rx NUMBER	DRUG NAME	DRUG NUMBER	DATE FILLED	BRAND NEEDED
1.					YES NO
2.					YES NO
3.					YES NO
4.					YES NO
5.					YES NO
6.					YES NO
7.					YES NO
8.					YES NO
9.					YES NO

INS. PAYMENT	PRESCRIBING PHYSICIAN'S NAME	PHYSICIAN CODE	DAYS SUPPLY	NEW Rx OR REFILL	NO. UNITS DISPENSED	AMOUNT CHARGED
						$
						$
						$
						$
						$
						$
						$
						$
						$

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.

I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

TOTAL CHARGES	
AMOUNT TO BE PAID BY MEDICAID	
AMOUNT TO BE PAID BY RECIPIENT	
AMOUNT TO BE PAID BY COUNTY	

PROVIDER'S SIGNATURE _____ DATE _____